# Massachusetts Department of Mental Health

## *Working Together for a Better Tomorrow*



## *Annual Report*

*Fiscal Year 2000*

***Commonwealth of Massachusetts***

**Argeo Paul Cellucci**
GOVERNOR

**Jane Swift**
LIEUTENANT GOVERNOR

**Marylou Sudders,** COMMISSIONER
DEPARTMENT OF MENTAL HEALTH

# *COMMONWEALTH OF MASSACHUSETTS*

## Department of Mental Health

### Mission Statement and Guiding Principles

The mission of the Department of Mental Health (DMH) is to improve the quality of life for adults with serious and persistent mental illness and children with serious mental illness or severe emotional disturbance. This is accomplished by ensuring access to an integrated network of effective, efficient and culturally competent mental health services that promotes consumer rights, responsibilities, rehabilitation and recovery.

***DMH is committed to the following principles:***

1. Providing responsive, high quality, cost-effective services.

2. Focusing support on the most vulnerable citizens in the Commonwealth.

3. Designing programs using current scientific research, evaluation studies and program outcome data.

4. Promoting opportunities for individuals with mental illness to participate in rehabilitation and recovery regardless of how severe their symptoms or pervasive their illness.

5. Offering individuals appropriate choices among services tailored to meet their unique needs.

6. Valuing managers who engage their colleagues and staff in entrepreneurial, innovative leadership that will improve the system.

7. Valuing input from a wide public audience and recognizing that community advocacy and advisory groups are an essential component of system planning.

8. Eliminating barriers to services.

9. Exploring and applying new technologies to ensure quality, cost-effectiveness and the efficient use of public resources.

10. Assuring that the cultural and ethnic diversity of clients and staff are respected in the design and delivery of services.

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Mental Health
25 Staniford Street
Boston, Massachusetts 02114-2575

JANE SWIFT
*Governor*

WILLIAM D. O'LEARY
*Secretary*

MARYLOU SUDDERS
*Commissioner*

Area Code (617)
626-8000
TTY 727-9842

To: Interested Parties

From: Marylou Sudders

Re: Annual Report

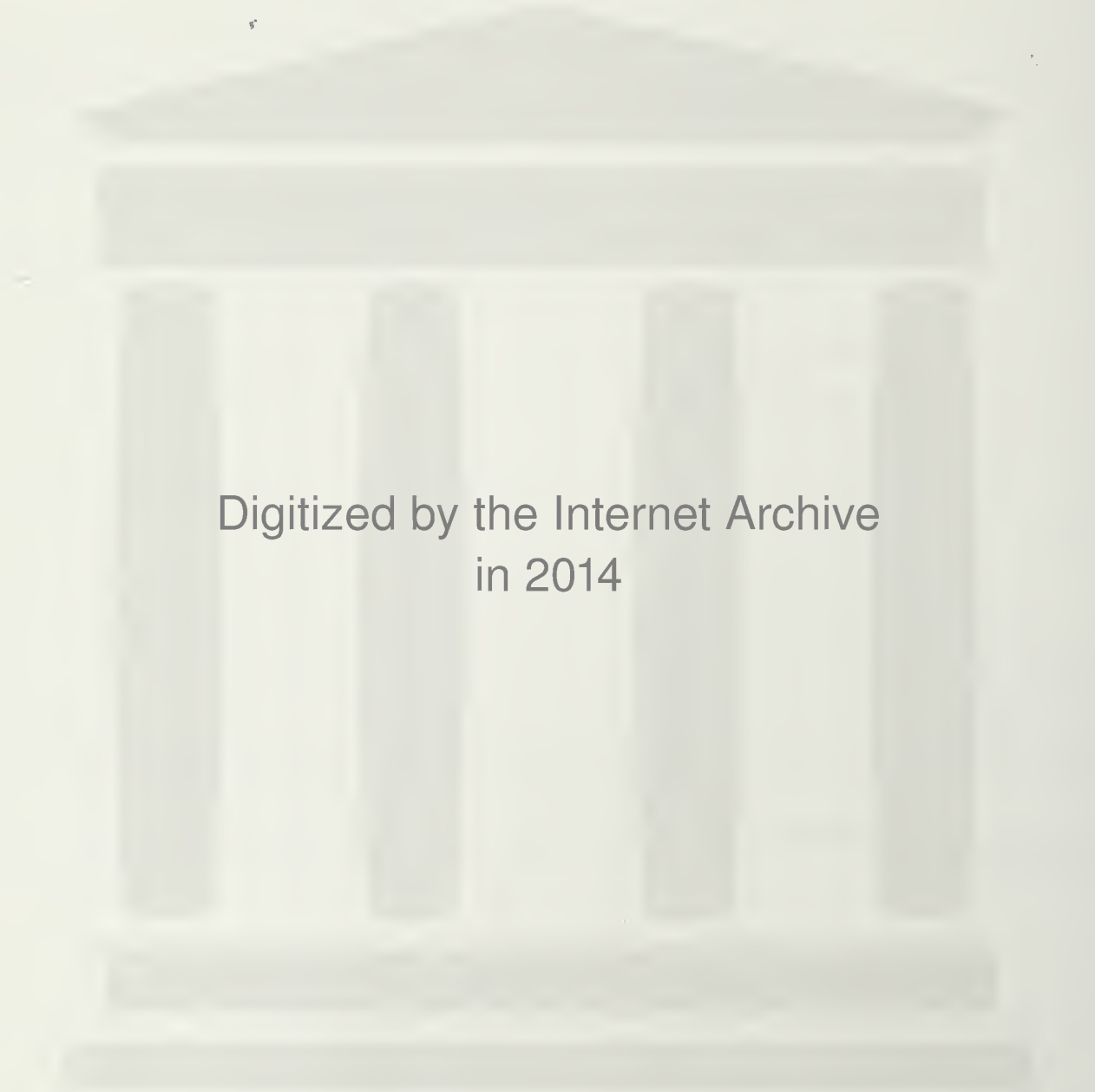
Date: April 25, 2001

---

Enclosed is a copy of the Department's Fiscal Year 2000 Annual Report.

It provides an overview, a summary of major accomplishments within DMH in the last fiscal year and a look ahead. I hope that you will find it useful and informative.

Please contact the Public Affairs Department at (617) 626-8158 if you would like additional copies.



# Unequal Mental Health Care No Longer Acceptable

Mental health must be an essential component of health care. This has been affirmed by no less than the U.S. Surgeon General, David Satcher, M.D., the nation's doctor. "Today, a strong consensus among Americans in all walks of life holds that our society no longer can afford to view mental health as separate and unequal to general health," he said in the first-ever Surgeon General's report on mental health, released in December 1999. "Mental health is fundamental to health."

The findings and pronouncements in *Mental Health: A Report of the Surgeon General* are still reverberating. Advocates, legislators, journalists, professional organizations and others herald it for what it says and how it says it. There is a wealth of information. "One in five Americans has a mental disorder, but many do not seek help and mental disorders such as depression, schizophrenia and bipolar disorder are real illnesses that are as disabling and serious as cancer and heart disease in terms of premature death and lost productivity." There also is a simple, clear message: "Seek help if you have a mental health problem or think you have symptoms of a mental disorder."

People pay attention when the Surgeon General speaks. He lends stature to an issue that many of us know from first hand experience. He provides an incredible national platform that, among other things, preaches the unmistakable message that the call for mental health insurance parity, which specifies equity between mental health and other health coverage, should be heard.

During the past fiscal year, this message was heard in Massachusetts. The landmark parity legislation unanimously adopted in the House and Senate and signed by the Governor tears down some of the barriers that have allowed stigma and a sense of hopelessness to prevail. What has been true nationally has been true in the Commonwealth. Mental health has been plagued by disparities in the availability of and access to services. A key disparity has hinged on an individual's financial status. This is why parity is so important.

Mental illness is still too often relegated to the rear of our national consciousness. It is often spoken of in whispers, with accompanying shame. We must confront these attitudes, the fear and misunderstanding that have led society to this point. Education provides the means to change perceptions and we must all be educators.

Mental illness is an equal opportunity disorder. It ignores socioeconomic status, gender, ethnicity and political persuasion. Yet it is still spoken of in hushed tones as cancer was 40 years ago and AIDS was 25 years ago. Mental illness is our country's quiet epidemic. It is the stepchild of health care, segregated from the mainstream. We must eliminate all of the federal, state and local barriers that continue to perpetuate this segregation if we want to change society's perception.

The majority of individuals with severe mental illness continue to live in the shadows of society without access to the treatment and supports critical to recovery. Unemployment, homelessness, criminalization, poverty, premature death still too often mark the lives of those trying to overcome psychiatric disorders. Mental illness is misunderstood and feared. One of our greatest challenges is combating stigma because people with psychiatric disorders will never be fully accepted as members until society acknowledges that mental illness is not something to be feared.

The discrimination that accompanies mental illness still drives the Department's agenda. It is no longer acceptable to set mental illness apart from every other type of physical illness, whether the discussion concerns insurance, housing, employment or access to treatment. Parity in insurance coverage of mental illness is the law come January 1, 2001. Vigilance will ensure compliance and we must be ever vigilant.

***Commissioner Marylou Sudders***

There will be quick reaction when indications arise that a health care provider is segregating mental health, particularly when it involves eliminating an essential service as a cost-saving measure. Too often, psychiatric services are the first thing on the table when the bottom line turns red.

While the Department provides for the needs of many people with psychiatric disorders, the needs are great. Housing, residential supports and case management have continued to grow. And we must provide intensive community support, such as PACT teams and peer support programs. These services promote treatment, rehabilitation and recovery.

The DMH engaged with individuals who are homeless, mentally ill and have dual diagnoses; developed services to reach increasingly diverse populations; and reaffirmed its support of research and training. There is resolve in attacking the immediate mental health crisis of kids waiting in emergency rooms for treatment of psychiatric disorders and moving others who are clinically ready out of hospital beds and into residential treatment. But we must do more. Together, we will face future challenges and continue to make a difference in the lives of people who need the public mental health services the Commonwealth offers.

# Mental Health Insurance Parity Tops List of FY2000 Accomplishments

Mental illness is an illness, not a character flaw. It responds to specific treatments, just as other physical ailments respond to medical interventions. The enactment of mental health insurance parity legislation into Massachusetts' law during the fiscal year provides opportunities for more people to receive the treatments they need on what is often a long journey to recovery. There has been no change in insurance coverage for mental health since 1973.

Both the House and Senate unanimously approved mental health parity, which eliminates longstanding insurance discrimination, and Governor Cellucci, a staunch supporter, signed the legislation into law May 2. As the Governor said when signing the measure, "this abolishes a double standard that has existed for far too long."

***Governor Cellucci announces that the mental health insurance parity bill has become law as the legislation's supporters look on.***

Many people worked diligently on this issue and through the efforts of the Governor and key legislators there is reason for renewed hope that mental health insurance parity rights a historic wrong in this state. Insurance coverage increases the acceptability of the illness and addresses the stigma and discrimination so often encountered by individuals and families.

The law, effective January 1st of 2001, provides full mental health insurance benefits for adults, children, and adolescents under 19 who have biologically based brain disorders such as schizophrenia, severe depression and bipolar disorders. In addition, insurers are required to provide a minimum of 60 days of inpatient care and 24 outpatient visits for non-biologically based disorders, such as adjustment disorders. Children may receive additional visits, even if not for treatment of biologically based disorders, provided there is clinical documentation that a child's emotional or behavioral disturbance will substantially interfere with or limit functioning.

Neuropsychological assessments and psychopharmacological services will be covered in full and will not be counted as part of the 24 outpatient visits. The benefits also will cover individuals with mental illness and co-occurring substance disorders. The law provides insurers with the same access to mental health records as they have to all other medical records. It requires consent of the insured or covered family member before patient information may be disclosed. Only licensed mental health professionals may deny services. The cost will be negligible.

Although mental health still remains in the shadows of health care, insurance parity will do more to bring it into the light by eliminating financial barriers to accessing treatment. As a society, however, health care still evokes thoughts of physical health, not mental health. Yet serious mental illnesses and behavioral disorders affect nearly 1 in 5 Americans every year. It is important that these illnesses be recognized as such. They are society's hidden epidemic and they impose enormous financial and emotional burdens.

In addition to playing a key role in the process leading to the parity law, the Department was active in other endeavors in FY2000. A major ongoing activity that moved forward involved individuals from nearly every corner of DMH. After lengthy negotiations, the Department signed a contract with Data General Corp. (hardware) and Meditech (software) to develop the Mental Health Information System (MHIS). The program , which was launched in FY2000, is occurring in three overlapping phases and is expected to take approximately two plus years. DMH is customizing the Meditech software system to fit its clinical and business environments. System implementation includes: admissions, administrative and billing procedures in the Department's inpatient facilities; application to DMH community-based services and case management; and development of an elec-

tronic medical record for patients in the facilities. When fully implemented in FY2002, MHIS will enable the Department to monitor all services either directly provided or funded by DMH for continuing care clients, track expenditures and retrieve clinical information.

A number of factors continue to affect mental health care for children and adolescents in Massachusetts. Many children who are clinically ready to receive less intensive post- hospitalization services remain in high cost, intensive services, such as inpatient, secure intensive residential treatment or acute residential treatment beds. There continue to be waiting lists for residential support and case management for these youth and reduced lengths of stay in acute care hospitals have become the norm. The service problem at the community level is exacerbated by direct care salaries that have not kept pace with inflation in a dynamic economy and a competitive labor market, leading to an inability to hire and retain qualified workers. In response to concerns expressed about children waiting for post-hospitalization services in FY2000, the Governor has proposed a $10 million appropriation in the FY2001 budget. The funds will enable DMH to better address post-hospitalization needs of children and adolescents in Department of Social Services care.

In FY2000, the Department was awarded a grant from the Center for Mental Health Services for Comprehensive Mental Health Services for Children and their Families. This grant will support development of a culturally competent system of care for children 8-13 and their families in Worcester. Funds from several state agencies are being pooled to support this project. Ongoing interagency initiatives for children and adolescents included fine-tuning of the DMH/Department of Social Services Collaborative Assessment Program (CAP) for children at risk of out-of-home placement, which was piloted in the Southeastern Massachusetts Area in FY1998 and expanded statewide in FY1999. Outcomes from this initiative continue to be positive.

During FY2000, the Department continued collaborative efforts to promote interagency cooperation and systems integration for additional shared populations. These included the interface between DMH clients and their primary care providers, issues concerning people with mental illness and co-occurring substance disorders.

Access, education, support systems

*Commissioner Sudders joins the first participants of a multicultural training initiative, which focuses on attracting minority professionals to the Department.*

## 1700-2000

| | |
|---|---|
| Care of insane delegated to relatives, jails, almhouses and overseers of the poor | 1700 |
| Responsibility transferred to judges who relied on opinions of "Board of Overseers of Poor and Selectman" | 1736 |
| Law passed permitting the commitment of lunatics "furiously mad as to be rendered dangerous to the safety of good people to be at large" to commitment in the House of Correction | 1788 |
| Massachusetts General Hospital and McLean Hospital established | 1811 |
| First pauper institute established in Worcester | 1833 |
| Dorothea Dix testimonial to Massachusetts Legislature on deplorable conditions in jails and almhouses | 1843 |
| Massachusetts State Board of Charities established. First time "insane" came under state supervision | 1863 |
| Resolve passed authorizing the appointment of a commission to investigate state's mental health system resulting in State Board of Insanity | 1896-1898 |

| | |
|---|---|
| Boston Psychopathic Hospital (later Massachusetts Mental Health Center) opens | 1912 |
| First outpatient clinic opens at Danvers State Hospital | 1914 |
| State Board of Insanity replaced by Massachusetts Commission on Mental Diseases (later Massachusetts Department of Medical Diseases) | 1916 |
| Massachusetts first state to establish a Division of Mental Hygiene for children of pre-school age | 1922 |
| Special Commission Report creates Department of Mental Health (DMH) | 1938 |
| Dr. Erich Lindemann establishes first community mental health center in United States | 1948 |
| Massachusetts inpatient census reaches high of 23,560 | 1953 |
| Massachusetts Mental Health Planning Project develops strategy for implementing community mental health service network | 1963 |
| MGL735 (community mental health and retardation act) restructures services delivery system into 40 area offices and area boards | 1966 |
| Phasing down of inpatient census as community services are developed | 1966-1974 |

and prevention remain the key factors in providing more appropriate medical care for people with mental illness living in the community. During FY2000, additional emphasis was placed on enrolling DMH clients in MassHealth and other entitlement programs. This included in-service programs for case managers concerning the application process, education, support and outreach regarding benefit utilization and additional education of consumers on the appropriate use of hospital emergency rooms. Many individuals already enrolled in MassHealth still do not fully understand the scope of their health care coverage.

During FY1999, DMH completed phase one of a federally funded Substance Abuse and Mental Health Services Administration (SAMHSA) grant to reach consensus for treating individuals with a dual diagnosis of mental illness and substance disorders. The principles adopted on this project, which integrates treatment of mental illness with treatment of substance abuse as primary disorders, were incorporated into the requests for proposals and included in contracts for residential services that were advertised for bids in FY2000. As a result, all residential programs are now required to understand and address the needs of dually diagnosed clients through program linkage to substance abuse services in the community or by providing specialized services in residential settings. In addition, the Department's eligibility criteria were modified to assure that individuals with substance disorders were not automatically excluded. The new criteria specifically allows people with serious mental illness and substance disorders to be considered eligible. There are committees set up in each DMH Area to guide this work.

The Office of Multicultural Affairs, established in FY1999, achieved key objectives during the fiscal year. These included the release of a position paper, approval from the Commissioner to modify the mission statement of DMH and start of work on a three-year Cultural Competence Action Plan.

The Department continued to send its forensic mental health transition teams into Department of Correction facilities and Houses of Correction. The teams work with inmates with serious mental illness who meet DMH eligibility criteria and are scheduled for release. They ensure continuity of care in the community. The results of this collaboration continue to produce positive outcomes in the form of reduced recidivism. The forensics division also continued other collaborative activities with various arms of the criminal jus-

*Kid consumers show creativity at an after school program by making African Masks during Black History Month.*

*Children at Taunton-Attleboro Therapuric Activity Program work on an art activity.*

tice system, including parole boards, probation officers and the Juvenile Courts. During FY1999, the Department took over management of all juvenile court clinics in the Commonwealth, which provide evaluation and sentencing assistance to juvenile court judges. This will be expanded in FY2001.

With funds specifically appropriated by the Legislature for FY2000, the Department developed a residential community program for adults with Acquired Brain Injury (ABI) who had been long-stay inpatients in the DMH system. The clients moved into the program during the fiscal year. Community living has posed significant challenges to both clients and program staff and there was a steep learning curve involved. DMH provided staff with neuropsychiatric consultation to assist in the transition. The Department also enhanced services in existing community programs, allowing several other adults with ABI to step down from hospital levels of care. DMH participates in trainings with other state agencies to raise awareness, discuss differential diagnosis and promote appropriate evaluation and placement of this population.

The last part of the Department's new regulations, on service planning, became effective July 1, 1999. Service planning defines the term client, eligibility for services, case management and individual service plans (ISP). Planning for implementation included preparation of detailed guidelines that were distributed to Area and Site offices.

The Commonwealth Research and Evaluation Unit was transferred from the Massachusetts Mental Health Center to new quarters at the Erich Lindemann Mental Health Center in Boston. Research at the statewide unit, part of DMH's Research Centers for Excellence, covers medication studies, first-episode psychosis, dual diagnosis, prevention and women's mental health issues.

## *DMH Overview*

| | |
|---|---|
| Closing of 12 state hospitals | 1973-1993 |
| Brewster Consent Decree mandating establishment of comprehensive system of community residency and less restrictive institutional treatment (DMH disengaged 1992) | 1978 |
| Executive Order 244 signed – prohibiting children/ adolescents under 19 from being treated on adult inpatient units | 1984 |
| Governor's Special Message on Mental Health- a long range plan to dramatically improve and expand the community mental health system | 1985 |
| Chapter 599 split Department of Mental Health (DMH) and Department of Mental Retardation (DMR). Created new mission for DMH effective July 1, 1988. | 1986 |
| Commonwealth establishes a first-in-the nation Medicaid contract for mental health and substance abuse | 1992 |
| All inpatient facilities are accredited by the Joint Commission on Accreditation of Healthcare Organizations and certified by the Health Care Financing Administration | 1997 |
| Mental health insurance parity legislation enacted eliminating long-standing discrimination in insurance practices | 2000 |

A new $1.6 million, 8,548 square-foot recreation building was opened on the grounds of Taunton State Hospital. The gymnasium is the first new stand-alone facility built at any campus of the Department of Mental Health's state hospitals since 1994. The structure, located near the main administration building, includes a lobby; a gymnasium with official volleyball and full-length basketball courts; ample program/activity space; a kitchen, equipped with a handicapped accessible sink; wheelchair-accessible restrooms; a handicapped accessible shower; 450 feet of storage space for gym equipment; and an office for rehabilitation staff. All utility controls are key operated for safety. The building, equipped with a forced hot-air heating system and air conditioning, is serving many of the 185 patients being treated at Taunton. The gymnasium has a rubberized, polymer resin compound floor, protection panels on the walls, sprinkler and infrared smoke detection systems. It has a capacity to serve about 230 people. The facility provides much needed additional rehabilitation program space, as well as leisure time recreational programs. A joint legislative-executive branch initiative to name the building will occur in the next fiscal year.

The new 32,000 square foot Irving S. and Betty Brudnick Neuropsychiatric Research Institute, a state-of-the-art biological research facility adjacent to the Bryan Building at Worcester State Hospital, was dedicated and staff began looking into the causes, diagnoses and treatment of chronic and serious psychiatric disorders. This was a joint DMH-UMass collaboration.

More than 40 DMH staff volunteers from Worcester State Hospital provided around-the-clock, week-long emotional support and counseling to firefighters and their families in the wake of a December 3, 1999, warehouse blaze at the Worcester Cold Storage and Warehouse Co. that claimed the lives of six firefighters.

*U.S. Surgeon General Dr. David Satcher (left) and Commissioner Sudders at the national DMDA convention in Cambridge.*

The Silvia-Cozzens Scholarship Awards, which commemorate the lives of longtime DMH mental health workers Richard Silvia and Paul Cozzens, were created and awarded to eight students in a Licensed Practical Nurse program. The LPN program provides training and career ladder opportunities to staff.

The Department continues to work on changes in the civil commitment process for individuals who are involuntarily admitted to a hospital due to imminent risk of harm to self or others by reason of mental illness. This would be the first major change in the process in 30 years. Work has centered on reducing the time for judicial hearings on petitions for civil commitment, and emergency hospitalizations and notification for appointment of a lawyer. Legislation was expected to be passed during informal sessions.

Significant challenges remain. Community service providers have not received rate increases to base contracts for several years and this combined with low unemployment rates have made it increasingly difficult for service providers to attract, train and retain mental health workers for many community programs that serve DMH clients. To ameliorate the problem and reduce staff turnover in these programs, the Commissioner announced in FY1999 that there would be a salary floor of $20,000 for all direct care workers included in the request for proposals for residential programs issued during FY2000 and FY2001.

DMH still has more clients than service availability. The year-end report on service needs of adults, children and adolescents showed 20,100 individuals waiting for residential support and case management services. The data showed 3,220 adults waiting for residential support services and/or housing. A total of 220 children and adolescents were awaiting residential services and housing placements. In addition, 16,661 adults and children were waiting for case management. The numbers have increased steadily since December 1998 when the Department began collecting more accurate accounts on those waiting for services.

# *Working Together to Promote and Enhance Mental Health Services*

The Department of Mental Health, which served an average of 26,000 clients in FY2000, provides quality, cost effective services to people with mental illness. The Department expanded community-based programs while meeting continuing care needs of individuals in public mental health facilities. At the same time, the waiting lists for residential support services and case management increased by nearly 1,000 adults, children and adolescents during the fiscal year.

The Department has made optimum use of budget increases averaging 2.4% since 1994 to address its unmet needs. Wherever possible, DMH has addressed increased service needs through restructuring and reallocation of base funding.

The FY2000 budget of $571.6 million, a 3.4% increase over the previous fiscal year, included $1 million to provide residential services for 31 additional adult clients in DMH inpatient facilities awaiting community placements; $500,000 allowing the Department to move 13 additional children out of intensive services; $2.1 million for the expansion of services to 135 more homeless mentally ill people; and $4 million for structural improvements to state psychiatric hospitals and community mental health centers.

Through FY2000, the Department received $32.7 million in new funds for growth since FY1989. Of the $32.7 million, $21.2 million has been earmarked specifically for the homeless mentally ill, which leveraged $71.4 million in housing support, mostly from federal sources. The remaining $11.5 million has been allocated to expand adult, forensic and child/adolescent services. Yet, the Department has expanded community-based services, and to a lesser extent, inpatient services, well beyond the $11.5 million.

The Department has been adept at directing resources to address its most critical needs by channeling savings created in other areas. For example, in concert with the Division of Medical Assistance (DMA), DMH joined an initiative in 1996 to provide acute inpatient and emergency services. Most acute care is now provided in a network of general and private psychiatric hospitals under contract to the Massachusetts Behavioral Health Partnership which, in turn, is under contract to DMA. In FY2000, the Department purchased $27.2 million in acute care services for DMH clients through an interagency agreement with DMA. Department savings realized since 1996, including retained revenue from emergency services, have reached $19.4 million. DMH has invested the savings in expanded community-based continuing care programs that are central to ensuring that clients move appropriately through the mental health system.

The Department has reinvested $65.8 million since restructuring and consolidating facilities in 1992. These funds have been used for inpatient and community-based services. DMH committed 61.7% of its $571.6 million FY2000 budget to community-based care, up from 49% in FY1991. It is interesting to note that in 1953, a total of 23,560 people with mental illness were treated in state psychiatric hospitals. During FY2000, all but about 2,390 of the 26,000 DMH clients were treated in the community.

The following provides a look at the DMH system across the Commonwealth:

## Acute Care

*Interagency Service Agreement with Division of Medical Assistance*

After closing four inpatient facilities in 1992-1993, DMH contracted with 10 certified and accredited public, private and general hospitals in the community. In July 1996, DMH entered into its interagency service agree-

***A crowd gathers to celebrate the opening of the new recreation building on the grounds of Taunton State Hospital.***

*Keith Lockhardt (center), Boston Pops conductor, performed with Northeast Area kids in the sixth annual Night at the Wang. The performance, a culmination of eight months of rehearsals and set design, brings together professional performing artists, volunteer educators, and children ages 6-19 in DMH residential programs.*

ment with Division of Medical Assistance to provide acute care through a network of general hospitals with psychiatric units and private psychiatric hospitals across the state. These hospitals are under contract to the Massachusetts Behavioral Health Partnership, the Division of Medical Assitance's managed care organization. This purchasing arrangement, covering Medicaid recipients and non-Medicaid DMH priority clients, strengthens both acute and continuing care services by expanding the vendor network, solidifying emergency services for people in crisis, and providing greater coordination between agencies. The DMA/DMH partnership replaced the aforementioned DMH acute care replacement beds and designated emergency treatment programs.

### *DMH/DMA Savings Help Expand Services*

DMH has utilized annual savings from the behavioral managed care initiative, which total approximately $19.4 million since inception, to expand needed community services for adults and children. During the first year alone, DMH reinvested $9 million in savings to expand continuing care. Services developed or improved included: expanded residential options for children and adults; in-home treatment for children and adolescents; flexible supports for adults and children in the community; case management services; dual diagnosis treatment; clubhouses; day treatment and skills training; and supported employment. The funds have been distributed in a manner that addresses historic inequitable resource distribution among DMH's six Areas.

## DMH Inpatient Care

### *State Hospitals/CMHCs*

DMH continues to directly operate 11 inpatient facilities statewide – four state hospitals, five community mental health centers (CMHCs) and mental health units in two Department of Public Health hospitals. The Department's psychiatric hospitals include Medfield (147 beds); Worcester (176 beds); Westboro (221 beds — 30 are for adolescents); and Taunton (185 beds — 16 are for adolescents). In addition, DMH provides an array of specialized services in state facilities for people with mental illness involved with the criminal justice system.

The Department's mental health units in DPH hospitals include: the Hathorne mental health units at Tewksbury Hospital (180 beds) and the Metro Boston mental health units at Shattuck Hospital (125 beds).

Three of the five CMHCs outside Metro Boston have 16-bed acute care inpatient units (Quincy, Corrigan in Fall River, and Cape and Islands at Pocasset). Two centers, Brockton Multi-Service Center and Solomon in Lowell, do not provide acute or continuing inpatient care.

In the Metro Boston Area, two of the three CMHCs provide inpatient care: Lindemann (42 beds) and Solomon Carter Fuller (36 beds).

*Contracted Inpatient Treatment*

DMH contracts with Olympus Hospital in Springfield to provide continuing inpatient care for 30 adults in Western Massachusetts. For children ages 5 through 13, DMH contracts for a 16-bed inpatient unit at Westwood Lodge.

**Total DMH beds = 1,218**

## Community Services

*Child/Adolescent Programs*

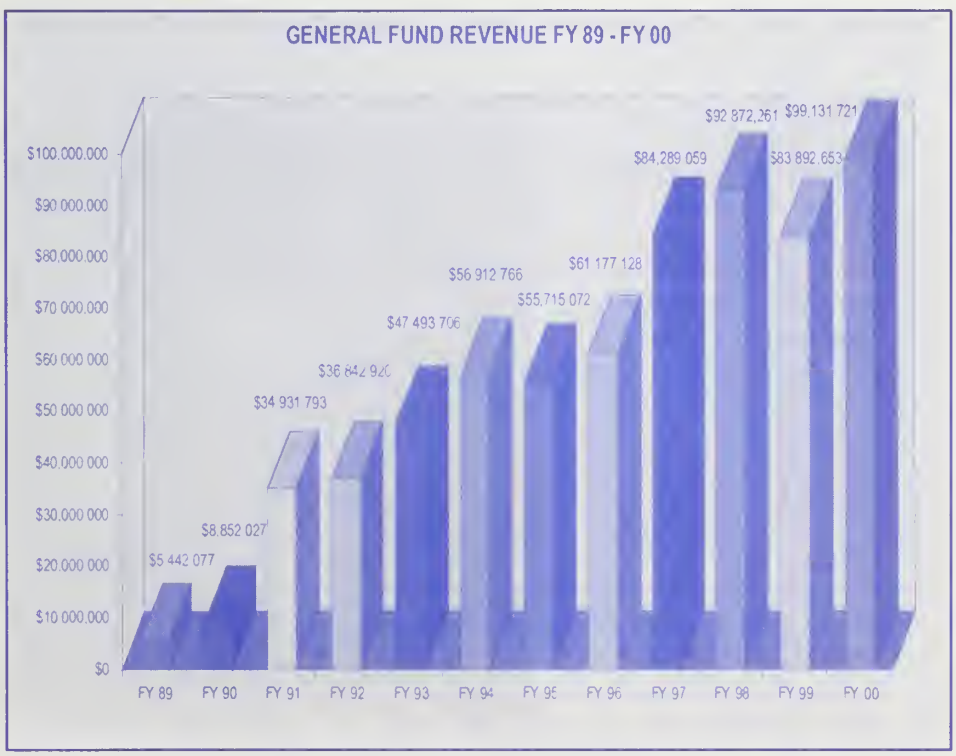
A network of community-based services, which provides early intervention and intensive programs to reduce the need for out-of-home placements, enables children to make treatment gains and to function in community settings. The following initiatives have been undertaken: development of short-term crisis stabilization services and after-school programs for latency-age children; expansion of school-based contracts to include violence prevention programs; expansion of family support contracts; broadening of existing interagency teams; and earmarking of resources to purchase "wraparound" services tailored to meet a child and family's needs.

DMH contracts for two secure Clinically Intensive Residential Treatment programs (CIRTs) for children (ages 5 through 12): the Everett House (11 beds) operated by the Home for Little Wanderers in Boston; and Three Rivers (12 beds) operated by Northampton Center for Children and Families in Springfield.

Intensive Residential Treatment Programs (IRTPs) for adolescents (ages 13 through 18) include: Centerpoint (14 beds) operated by Justice Resource Institute in Tewksbury; Chauncy Hall (16 beds) operated by Northeastern Family Institute at Chauncy Hall/ Westboro State Hospital; the University of Massachusetts Intensive Residential Treatment Program (15 beds) at Worcester State Hospital; the Home for Little Wanderers Intensive Residential Treatment Program (16 beds) operated by the Home for Little Wanderers at Taunton State Hospital; Solomon Carter Fuller Mental Health Center (14 beds) operated by Vinfen for a total of 98 secure beds.

The Collaborative Assessment Program (CAP) is a DMH-DSS project that provides a single point of entry to state services for families not previously involved with DSS or DMH who have a child with serious emotional disturbance and is at-risk of out-of-home placement. CAP offers intensive wraparound services and, if necessary, short-term placement and links parents with other parents who have had experience raising children with serious emotional disturbance in the community. Jointly developed operational standards, DSS-DMH supervision of the CAP director, and ongoing training assure uniformity in program operations and data. The Parent Professional Action League conducts the training for the parent partners. The latest evaluation data shows that the CAP has been successful in preventing out-of-home placements. In FY1999, CAP served 308 families. At the six-month follow-up, out-of-home placement had been avoided for 60% of the children.

The Mental Health Services Program for Youth (MHSPY), a replica-



tion project with the Robert Wood Johnson Foundation, has been accepting children since March 1998. It has been successfully demonstrating the efficacy of delivering integrated physical health, mental health and social services to children under the aegis of a health maintenance organization (HMO). This was the first project where state agencies committed existing operational funds and pooled them in an effort to provide coordinated service delivery. A steering committee comprised of DPH, DMR, DMH, DSS, DMA, DOE, DYS, Neighborhood Health Plan (the HMO) and parent representatives meets monthly to review program progress. MHSPY has provided a template for the design of wraparound services and interagency coordination being developed under the state's Child Mental Health Initiative Grant. It has served 39 children since its inception and 28 are still enrolled in the program. Only 5 have been moved to more restrictive settings.

# Adult Services

## *Community Living*

DMH developed more than 3,600 new residential beds in the community between FY1991 and FY2000. In addition, more than 823 individuals live independently and the Department assists clients in locating apartments in the open rental market. Housing opportunities have been expanded from a residential system serving 2,100 people with mental illness in 1988 to one that provided or purchased residential services for more than 6,278 clients as of the end of FY2000. This encompassed supported housing units where residential services are delivered, including group homes with four or more clients (2,882), independent living (3,252) and transitional psychiatric shelter beds (144). In addition to its adult residential program, the Department funded 309 beds for children and adolescents in community residential programs.

DMH had 248 residential contracts and spent $167.3 million on residential services for adults and children in FY2000. As of the FY2000 year-end report, 3,220 adults were waiting for housing and/or residential support services.

## *Employment*

Employers, squeezed by a tight labor market, are increasingly turning to people with mental illness, a group historically seen as one of the least employable, to meet their job needs. The Department is committed to helping individuals with mental illness identify and achieve career objectives through education, training and job placement. Successful employment programs promote rehabilitation and recovery by fostering reintegration of clients into the workplace and the community.

The Department spent $30.1 million of its $571.6 million FY2000 bud-

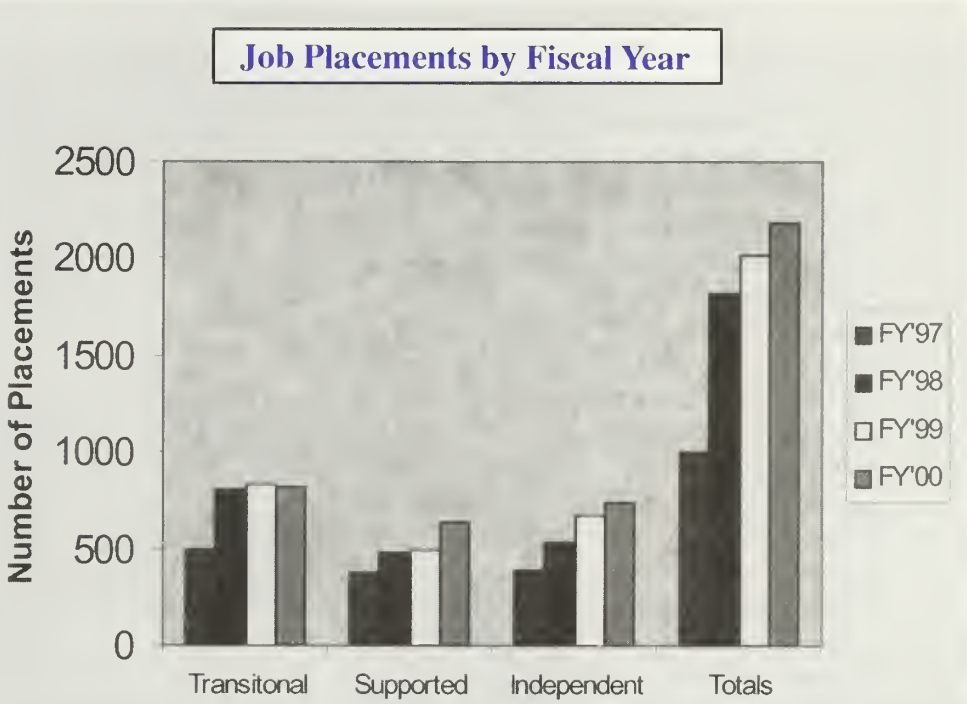
*Mike Cote, (from left) Director of Plymouth Bay Clubhouse; William Fitzgerald, Director of Dining and Nutrition at Bethesda at Evanswood; State Senator Therese Murray; Myron Ohanuissian, clubhouse member and Bethesda at Evanswood employee; and Linda Chuckman, Director of Community Relations and Volunteers, Bethesda at Evanswood at the Clubhouse Coalition's Annual Employer Recognition Ceremony.*

get on employment-related programs. Services were largely delivered through contracts with community-based providers.

More than half of the funding tied to employment ($16.1 million) supported 28 community support clubhouse programs, which operate under a "work-ordered day" and provide transitional, supported and independent employment services to members. In line with the "work-ordered day," all members are expected to participate in one or more operation units within the clubhouse. In this way, members receive valuable employment-related experience. Many members are provided assessment, job search, placement and counseling services to gain employment outside the clubhouse. An estimated 30% of a clubhouse budget is devoted to developing transitional, supported and independent employment opportunities for members.

According to the latest clubhouse employment survey, compiled by the Massachusetts Clubhouse Coalition, 780 employers provided jobs for clubhouse members during FY2000. Job placements increased from 2,015 to 2,191. The average hourly wage was $8.14 for clubhouse members in independent employment; $7.52 for those in supported employment; and $6.42 for members in transitional employment positions.

The Department's Services for Education and Employment (SEE) program is a $5.6 million statewide initiative emphasizing client choice in furthering education or receiving training and/or job placements. Providers under contract to DMH deliver program services in 22 community-based projects across the state. Clients are offered flexible, individualized supports with the goal of producing permanent employment with mainstream employers. SEE also works with clients requiring educational and job training services or more interim work placements before seeking independent, competitive employment. Through the end of FY2000, SEE programs placed 2,079 clients in jobs at an average wage of $7.08. There were 688 clients in educational placements.




Source:Massachusetts Clubhouse Coalition

To encourage the hiring of clients, the Department works closely with the Massachusetts Rehabilitation Commission and Department of Employment and Training (DET) in offering a federal tax incentive to for-profit employers. The Work Opportunities Tax Credit (WOTC) program allows employers hiring DMH clients participating in employment and vocational rehabilitation programs to receive tax credits as high as $2,400 for each individual hired. By providing a streamlined administrative process for employers, SEE vendors and clubhouses use WOTC as a job development tool. This initiative is designed to foster more competitive employment opportunities and reduce the stigma associated with mental illness through the hiring of qualified, competent employees.

Employment Connections, a Boston-based program, focuses on employment services for DMH clients who have recently been homeless. This partnership program with the DET and the Job Net Career Center provides clinical supports, career planning, job development and placement services. Job Net offers assistance in resume writing, identifying employment search skills, job readiness screening and sharpening of interview techniques. In addition to providing these job search and development services, Job Net also offers education and outreach services to DMH providers. The program

serves more than 130 DMH clients each year and develops approximately 65 job placements annually. Wages averaged $9.15 per hour in FY2000 and 20 of the 54 employers hiring Employment Connections applicants had previously hired people with mental illness. The program has been operating since FY1996 and is funded through state homeless dollars. DMH funding is used to purchase designated DET staff time allocated to clients of the Department. Local service site personnel provide support services.

Community support clubhouses offer housing search assistance, vocational training, temporary, part-time and full-time job placements, career development, supported education, meals and social contacts. Funding has been increased from $11.3 million in FY1991 to $16.1 million in FY2000. An additional $1.6 million was allocated for drop-in centers and social clubs for a total of nearly $18 million. This is an increase of $6.7 million since FY1991.

### *Case Management*

DMH has expanded case management, supervisory and support staff for adults and children. Between FY1992 and FY2000, the Department added 139 case managers, increasing from 342 to 481. DMH provides case management services to more than 11,781 individuals. A total of 14,164 adults and 2,497 children were awaiting DMH case management services at the end of FY2000.

### *Consumer-Run Initiatives*

During FY2000, the Department began funding a Peer Educators, Support and Advocacy project. This program, awarded to Vinfen Corp., will be implemented by consumers, advocates and Moe Armstrong of Vinfen in the Department's state hospitals in FY2001. The project seeks to assist mental health clients to better understand and cope with their illness. It also empowers people with mental illness to advocate on their own behalf and provides them with individual and group peer support.

A second initiative is the Consumer Satisfaction Team (CST) project. This program is run by Jonathan Delman and involves consumers interviewing consumers about their level of satisfaction with respective programs and services. The number of projects that the CST will be involved in is currently being negotiated. When a program is reviewed by this team, a report is generated with recommendations and a determination is made whether there is greater consumer satisfaction following implementation of the recommendations.

## Special Initiatives

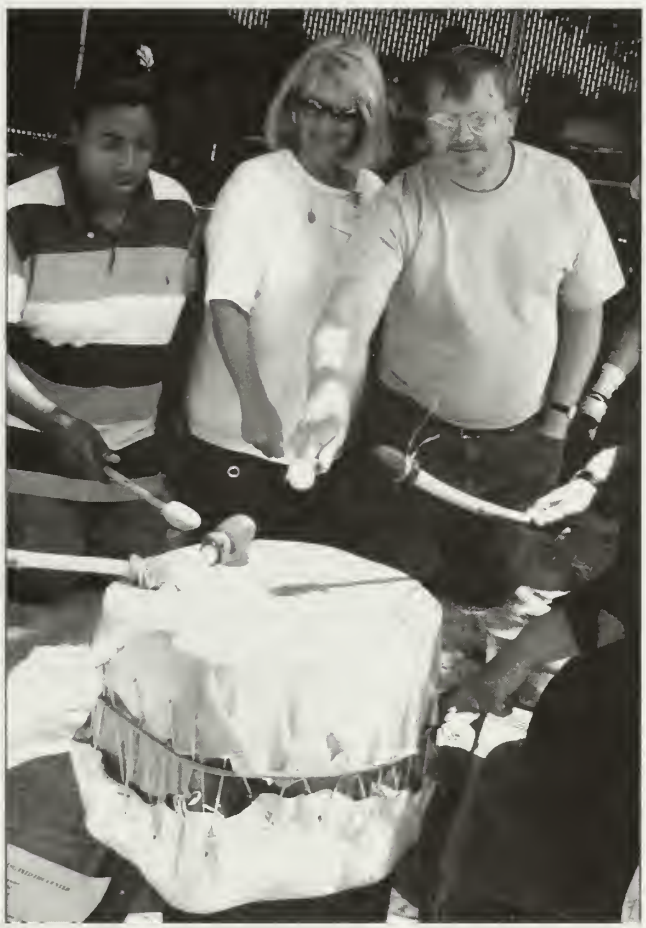
### *Homeless and Mentally Ill*

DMH operates a special initiative for people with mental illness who are homeless with $21.2 million in

***The Bridgewick Neuropsychiatric Research Institute was officially opened and dedicated in May at a ribbon-cutting ceremony.***

state appropriated funds for statewide service projects in FY2000. Through this initiative alone, 1,916 people with mental illness who were homeless were placed in housing with services through the end of June 2000. Since FY1992, the state's homeless mentally ill initiative has been used to develop or provide access to 961 new housing units. In FY2000, the Department received an additional $2.1 million to expand the homeless mentally ill initiative to 135 more individuals.

Through FY2000, DMH leveraged $71.4 million in housing, mostly through the U.S. Department of Housing and Urban Development programs. DMH homeless initiative dollars are used primarily to provide clinical and residential services and to leverage federal resources to fund development or access housing units. DMH dollars also are used to fund outreach programs to homeless mentally ill individuals in transitional housing (shelters), on the streets and in rural areas.



***Lakicha Johnson, Barbara Jones and David Cross try their hand at Indian drumming at Corrigan's annual multicultural festival.***

The DMH discharge policy is aimed at preventing homelessness. The policy states that the Department will not discharge a client from a state-run facility to a shelter or to the streets and that every effort will be made to help the client find adequate, permanent housing. DMH has instituted an enhanced discharge protocol for its Metro Boston Area, the area with the highest number of homeless people in the state (about 1,200 of an estimated 2,000 statewide.) Boston operates a homeless services unit which, among other things, monitors the discharge process and identifies supportive housing options for clients. All individuals discharged from state-operated facilities participate in individual service planning. This includes a hospital treatment team and case manager who determine residential and support needs as well as eligibility for entitlements. The Harvard Medical School Longwood Residency Training Program provides an elective rotation for residents, at the Massachusetts Mental Health Center, to help them learn more about the issues of homeless persons with serious mental illness.

Aggressive Treatment and Relapse Prevention (ATARP) is a supported housing program, with funding through a three-year $2.4 million HUD McKinney Grant, providing permanent housing to 60 chronically homeless individuals and families diagnosed with co-occurring mental illness and substance disorders. The goal of the program is to achieve independence and secure permanent housing by providing rehabilitation and recovery services. There are five contracted agencies, each with a capacity for housing 11 single adults and one family.

ATARP completed its second year of operation on June 30, 2000, with a census of 62 people comprised of 50 adults and 12 children residing in housing. There were 7 families in the program and 43 single adults. Sixty percent of program participants have remained in their housing for more than a year, with 58% reported to have remained alcohol and drug free. Of those who relapsed, 83% were able to return to the program after treatment.

## *Forensic Services*

DMH provides an array of specialized services for people with mental illness involved with the criminal justice system. In FY2000, DMH provided 932 evaluations of adults who came before the Commonwealth's courts.

In addition, forensic clinical specialists provided predischarge risk management evaluations for DMH hospital patients with a history of serious criminal behavior; conducted evaluations for the Board of Parole and

worked closely with state and county correctional facilities to provide continuity of care for mentally ill inmates transitioning to the community. DMH forensic transition teams helped more than 130 mentally ill persons make the transition from correctional facilities to community mental health services.

For FY2000, DMH allocated $1,431,476 on mental health services to 9 county correctional facilities. The quality of mental health services in these facilities is evaluated by DMH forensic clinicians. Services include screening and identification, crisis intervention, medication, evaluation for hospitalization and release planning. In the Hampden County Correctional Facility in Ludlow, DMH operates, in conjunction with the sheriff's department, a short-term (up to 14 days) inpatient unit, 13-bed specialized mental health unit (Evaluation and Stabilization Unit or ESU) for men and women. DMH also provides specialized liaison services at MCI Framingham, the state's prison for women.

In FY1999, DMH assumed responsibility for procuring and managing all clinical services for the statewide Juvenile Court. Juvenile forensic specialists, in juvenile court settings, provided evaluation and consultation services for judges and probation officers on an as-needed basis. In FY2000, juvenile forensic specialists provided consultation, evaluation and treatment services to approximately 3,000 children and families involved in the juvenile justice system.

## Measuring Performance

### *Quality Management*

The Department has a quality agenda and quality councils in all Areas. DMH's quality management training efforts include line staff, family members and clients who work on specific problem identification and problem-solving activities. Quality management performance standards and performance outcome measures are in place for providers. They have led to reductions in restraint and seclusion, improved treatment of the dually diagnosed, reduced hospital readmissions, and a reduction in readmissions of the same patient to multiple hospitals.

As a first step toward enhancing ongoing monitoring of restraint and seclusion (R/S) use in state-operated inpatient facilities and licensed hospitals, DMH revised its R/S reporting requirements in FY1998. In addition to the patient specific R/S reports, the Department now collects aggregate data from all inpatient units in Massachusetts. Reports are routinely produced comparing each hospital's restraint and seclusion use on a number of hours of service, total R/S episodes per 100 individuals served, average number of individuals in R/S per 100 individuals served.

*Eileen Merriera and Jim Pockwanse edit a monthly newsletter for Crossroads Clubhouse.*

### *JCAHO Accreditation*

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), a national organization, surveys facilities to ensure that high quality services are provided and evaluated in relation to national standards. All DMH operated public psychiatric facilities now meet JCAHO standards.

### *Licensing*

All Areas are responsible for the Department's licensing mandate with 10 full time licensers to address community residential licensing needs. DMH also licenses 59 general hospital psychiatric units and private psychiatric hospitals, which consist of 64 sites and 5 IRTPs.

*Field trips offer interesting and alternative therapeutic activity for kids.*

# Research

## *Centers for Excellence*

DMH funds two Research Centers for Excellence overseen by a statewide Research and Advisory Board, chaired by the Deputy Commissioner of Clinical and Professional Services, and comprised of members from the Centers of Excellence, clients and family members not associated with the research centers. These centers apply the best minds and talent in Massachusetts to advance treatment and rehabilitation modalities for chronic, persistent and severely psychiatrically ill patients. The two centers are The Center for Psychosocial and Forensic Services Research, affiliated with the University of Massachusetts Medical School, which concentrates on behavioral and forensic sciences, and The Commonwealth Research Center, affiliated with Harvard Medical School, which focuses on clinical neuroscience and neuropharmacology. These two DMH research centers further fund a Minority Research Center and Minority Fellowships as part of their ongoing programming. A portion of the Psychiatric Residency and Psychology Internship Training programs at medical schools in Massachusetts is also funded by the Department.

# Technology

## *Mental Health Information System (MHIS)*

During FY2000, DMH began preparing for implementation of the Mental Health Information System, a comprehensive, integrated client information system that will provide the Department with a single, statewide, integrated and automated system within which to enter, maintain and report client information. The project will be implemented through three phases over a two-year period.

During the first phase, Meditech, the system developer, conducted site visits across the Commonwealth to understand the Department's business processes. DMH assembled a number of project teams charged with developing standards for the new system and addressing a range of issues associated with implementing a system of this size. Four Phase I Standards Teams were formed, including General Ledger, Billing/Accounts Receivable, Registration and MIS/Reporting teams, as well as several project-wide teams covering communications and training. The Clinical Advisory Team (CAT) was formed as well.

The Standards and CAT Teams recommended customizations of standard Meditech software. The Training and Communication Teams developed strategies to prepare for implementation. The CAT Team and its subgroups worked on the clinical aspects of the system.

# Western Massachusetts Area

**James Duffy, Area Director**

The six local site offices in Western Massachusetts include Franklin/ Quabbin, Springfield, Berkshire, Westfield, Hampshire and Holyoke/ Chicopee and have a total population of 820,790 with 106 cities and towns located within 2,864 square miles. The Area has a diverse cultural and linguistic population that includes Hispanic and African-Americans, along with Russian, Slavic-Bosnian, Ukrainian and Vietnamese immigrants.

During FY2000, the Western Massachusetts Area served nearly 1,400 adults and 270 children and adolescents. Services provided to the adult clients included inpatient, residential, day rehabilitation, supported education and employment, clubhouse, community rehabilitative support, outpatient, drop-in/social club and respite. Child and adolescent services also included flexible individual and family supports as well as community and school support.

Some of the highlights of the Western Massachusetts Area in FY2000 included:

Rehabilitation of the Reed House in Westfield began in February. Previously a respite facility, it will provide permanent housing for eight mentally ill homeless individuals. Domus, Inc., is the developer of this project and will collaborate with Carson Center of Adults and Families as well as Forum House.

Leahy House was opened by the Mental Health Association of Greater Springfield (MHA) in Westfield on May 1, 2000, to provide transitional housing for three homeless mentally ill individuals. The Broad Street house was donated to MHA by Greater Westfield Associated Blind, Inc. An application is pending with the U.S. Department of Housing and Urban Development (HUD) for funds to create a Safe Havens Project at the site with the hope of serving up to six homeless mentally ill individuals.

The Next Step Project, a HUD/ McKinney program-funded grant, was approved for funding in May 2000. Seven homeless individuals with mental illness will receive permanent housing assistance along with job readiness assistance and skills training through the efforts of Human Resources Unlimited and MHA. The program links housing assistance and employment for homeless individuals with mental illness.

A monthly series of consumer recovery conferences was initiated under the guidance of Cheryl Stevens, MD, Director of Consumer Relations. Conference topics have included Substance Abuse in Extreme Emotional States; Employment and Recovery: Strategies to Leap Ahead; Humor, Health and Healing; and Mental Illness: Path or Pathology. Planned topics include: Financial Recovery; Recovery and Creativity: the Journey of the Artist; and Stress Reduction.

FY2000 was busy for the Western Massachusetts Area training department. During the year, the Western Massachusetts Area supported and provided 232 training programs totaling 12,000 hours. A total of 3,987 people consisting of consumers, family members, provider staff and DMH employees attended the trainings on such topics as computer training, first aid and human rights.

A two-week Adolescent Dialectical Behavior Therapy (DBT) intensive

***Michael Nagy, Director of Research, receives his 10-year recognition gift from James Duffy, Area Director, at the 3rd Annual Employee Recognition and Training Day held in May at Springfield. In the background is Babette Lanier, left, and RaeAnn Chase, from the Western Mass. Area office.***

training was held for Western Massachusetts DMH employees and providers of treatment to adolescents.

Provider/agencies news and events for FY2000 included:

Human Resources Unlimited (HRU) celebrated its' 30th anniversary. HRU saw an increased number of members in DMH programs and more members employed through transitional employment opportunities. Homeless services were expanded into Westfield, Holyoke and Chicopee. HRU was honored with the Business Excellence Award for its excellence in human services.

***Mental Health Association of Greater Springfield, Inc. opened the Leahy House on May 1st to provide transitional housing for three homeless individuals. This house is also home to MHA's Westfield outreach services.***

Mental Health Association of Greater Springfield (MHA) outreach team members were recognized for their efforts in the Springfield Tenancy Preservation Program, which helps families and individuals retain housing or find more appropriate housing and avoid eviction and homelessness.

Community Enterprises, Inc., consumer member Linda Stalker was accepted into the first Massachusetts Peer Advocacy Training Program. The grant, funded by M-Power, provided 14 weeks of classroom training followed by a 6-month internship.

DMA/MBHP/DMH (Springfield Case Management Office) began a pilot project to enhance communications between DMH, community psychiatrists and primary care physicians to focus on improving physical health care for the seriously mentally ill.

The Cleveland Street Program, operated by ServiceNet, opened in September 1999 to provide residential support for five individuals in the Greenfield area. This program has been an important next step for people who have attained goals in more highly staffed programs, yet do not wish to face the risk of loneliness and isolation that often results from living alone.

Martin Luther King, Jr. Community Center, a minority business enterprise, was awarded a DMH contract to provide community rehabilitation services in the Mason Square area of Springfield with a focus on the African-American community.

ICCD Accredited Clubhouses (Lighthouse, Starpoint, Quabbin House, Forum House and Green River House) are now "on-line" at Hope-America.org, an Internet site that provides information on mental illness.


***Consumers and staff enjoy themselves at the Millennium Open House that was held at the Westfield Site Office to welcome in the New Year.***

# Central Massachusetts Area

**Elaine Hill, Area Director**

The five local service sites that comprise the Central Massachusetts Area encompass 66 cities and towns and cover approximately 1,578 square miles. With a population of more than 759,980 people, services to more than 2,800 clients are provided through three site offices and Worcester State Hospital. The hospital provides continuing care inpatient and court evaluation services. The site offices in Grafton, Worcester, and Fitchburg oversee a range of integrated community-based services vital to client rehabilitation.

The Area embarked on an initiative to facilitate Dialectical Behavior Therapy (DBT) services for clients. This therapy is particularly well suited to individuals with borderline personality disorders. The Area hosted a day-long conference where representatives of several established programs in Western Massachusetts described their work.

A new health and wellness program was initiated to deal with medical problems and health risks experienced by clients. One of the program goals is to provide a mechanism for learning what interventions and health strategies work well. A wellness coordinator position was developed to work with clients concerning challenging health issues.

Other initiatives included:

To continue a goal of strengthening community affiliations and linkages, new relationships were established with the Regional Housing Alliance, the Easter Seals Society, the Good News Garage, and the City of Worcester's Office of Community Planning and Development.

Residential capacity was expanded to provide services to individuals ready for hospital discharge. There was also a significant increase in the number of individuals receiving housing support through clubhouses. Additional people were served with the acquisition of affordable and appropriate housing for individuals with less intensive service needs.

Residential services were expanded by a total of 13 housing units in the Worcester Area. The Genesis Club, with matching funds from DMH, received a McKinney grant to serve 12 homeless mentally ill individuals. The target population to be served are the clients who frequent the Public Inebriate Shelter. In addition, Steppingstones, an Area young adult program, expanded its capacity through additional funding from the Department. This modest expansion had a positive impact on the waitlist for this specialized service.

The Crystal House clubhouse was relocated in Gardner. This clubhouse has made steady progress in its programming over the past several years. Although the transition occurred late in FY2000, the program experienced immediate growth in attendance and participation. Crystal House, managed by North Central Human Services, Inc., now enjoys an attractive program site, new equipment, and more reasonable access to the residents of the downtown area. In support of these changes, DMH provided a 10% funding increase allocated toward operational costs and new program initiatives.

*In December, the Worcester community faced an immense tragedy when six firefighters died in the abandoned Worcester Cold Storage building. DMH employees from the Central Mass. and Southeastern Mass Areas were recognized for their efforts in providing emergency grief counseling.*

Membership in the Crossroads and Tradewinds clubhouses increased by 13% during the fiscal year. The number of individuals employed increased by 30%. The clubhouses and the Supported Education and Employment (SEE) program focused on career exploration and planning as part of rehabilitation. While work opportunities continue to be a priority, long term career planning and corresponding critical skills are the ultimate goal for individuals who are entering or reentering the workforce. The SEE program reported an impressive increase in the number of individuals enrolled in educational opportunities, most of which were at the college level. It exceeded its target in this area by 50%.

There were several initiatives developed during FY2000 focusing on teaching and supporting healthy lifestyle choices. Several educational opportunities were offered to support the reduction or elimination of smoking. In addition to opportunities offered by DMH, providers and the community, clients organized support programs that met regularly to address various healthcare concerns. Preventative healthcare and symptom recognition and management are an integral part of each program.

The Dual Diagnosis Task Force continued to provide educational opportunities to clients while the Dual Recovery Anonymous Group continued to provide mutual support and education. In FY2000, this group started training other organizations within the state, who were attempting to develop the model.

The Worcester site began a one-year pilot for a PACT program utilizing intensive case management with a goal of reducing hospitalization. The program completed a five-year research study with SAMHSA, which compared an intensive mobile treatment approach to a clubhouse model and its ability to support individuals living in the community. The pilot is currently serving 80 individuals, ages 19 and over who are Medicaid or DMH eligible clients, who may not readily respond to more traditional interventions.

With the Bridge of Central Massachusetts as the lead, Dialectical Behavior Therapy was operationalized within an eight-bed group home in Worcester. The Bridge is committed to careful data collection and analysis to objectively measure client progress.

As part of the development of FY2001 residential requests for responses, a comprehensive review of the Worcester residential continuum of care was completed. This resulted in significant modifications, including specialized residential services for clients who are parents, the development of a premotivational substance disorder residence and conversion of a generic group home to a Latino residence. Approximately $65,000 was reallocated from the existing budget to address some of the associated costs.

Aetna Street, a dual-diagnosis residence, was redesigned and clients have significantly increased the duration of their sobriety. For individuals that had been in the program for one or more years, their average length of sobriety in FY2000 was seven months. In addition, one individual had a 10-month length of sobriety, two remained sober the entire year and the three newest residents remained substance-free since their admission. While relapse does occur, its frequency and intensity has been reduced.

***Guru Simiran of Congress House talks with children about what makes a good neighbor at Plains Street Park outing in Milford.***

# Northeast Area

**Mark Fridovich, Area Director**

The Northeast Area is a large geographic landscape that includes 50 diverse communities. For example, Lowell has the second largest Cambodian Community in the country while Lawrence has a majority of Hispanic residents. The communities vary greatly in size, education, industrial base and financial resources and subsequently have diverse mental health challenges.

Although the communities are different, there are common goals. Through statewide initiatives, such as redefining the eligibility criteria, case management guidelines and rebidding programs, the Area worked to improve quality, effectiveness and efficiency of services for more than 5,000 clients. Evaluating, reallocating and prioritizing funds and staff for better service delivery is ongoing. Utilizing research to determine which treatment approaches work is important for mental health programs. This requires a willingness to look at the effectiveness of services based on how well clients are progressing toward rehabilitation and recovery. Education of staff is essential in a dynamic system where change is inevitable. The challenge is to shape the changes and ensure they are the most therapeutic possible.

Initiatives in FY2000 included:

The Northeast Area initiated a multi-year plan in FY2000 to significantly increase the number of clients employed. Due to a strong economy, employers have had difficulty filling positions. Given these opportunities, it was a good time to challenge the standard of 10% of disabled citizens employed nationwide.

The Changing Expectations conference, attended by 200 clients, staff, and family members, was the kickoff event. The goal was to challenge beliefs and attitudes and raise expectations about what is possible for individuals with mental illness in the workplace. The greatest barrier to successful employment is the erroneously held belief that people with mental illness cannot work. At the conclusion of the conference, all of the site offices developed a multi-year employment plan.

The Social Work Department of the Hathorne Units at Tewksbury produced another educational film in collaboration with TRG Productions of Boston. It is entitled STIGMA. The viewer is left challenged to look at his/her beliefs and assumptions about mental illness. Special credits go to Phyllis Stone and Marian Re who were the executive producers of the film. STIGMA will be used as part of a community education plan.

In the spirit of looking at client needs, the clinical and administrative staff used one of the five mental health inpatient units at Tewksbury State Hospital for a transition unit. Clients with privileges, who have a full-time day program either at the hospital or in the community, were referred to the transition unit from one of the other four units. Structured groups, focusing on re-entry into the community, were available and included self-administration of medications, keeping appointments, utilizing community resources and Liberman Community Reentry Training Skills.

As part of a self-evaluation process, child and adolescent services reconfigured existing resources to implement outpatient/flexible support programs. Each site now has a part-time parent coordinator working closely with the interagency wraparound team and the outpatient/flexible support program.

*For the first time, more than 50 walkers from site programs and the DMH Site Office joined with local businesses to fight stigma in the Haverhill Area during May is Mental Health Month.*

*Last fall, Pioneer House moved into new quarters in Peabody. Built in the 1800s, lead and glass windows, chandeliers and woodwork typical of the era add dignity to the work-ordered day.*

While each outpatient/flexible support program is at a different stage of development, they are each part of a site-based team. Energy, creativity, and enthusiasm in the process lead to maximizing the use of resources, intensive family services and outreach to the community. Examples of expansion include: increased intensive home-based family therapy, more parent support groups, a variety of therapeutic and socialization groups run in other community locations and trainings offered to parents.

The residential system for adults, children and adolescents was reprocured in FY2000 and resulted in reconfiguration of resources and services based on needs assessments. Most DMH clients need subsidized housing, whether they are supported by residential contracts or by other DMH services, such as case management or Assertive Community Treatment (ACT) teams. The tight housing market required working closely with nonprofit developers to provide affordable housing for clients. The following projects were completed and began providing services during FY2000 (with subsidies from a variety of federal and state programs): Whittier School Apartments, Amesbury (capacity 10), Colburn School Apartments, Lowell (10), Parker Street Apartments, Lawrence (8), Haverhill Clubhouse Apartments, Haverhill (3).

***Owen Sargent visits with Andria in his new apartment in the Haverhill Clubhouse. Exposed brick, hard- wood floors and oversized windows add to the beauty of this facility.***

Training and information on rental subsidies, public housing and housing search techniques for case managers, provider staff, and clubhouse members also were also expanded.

# *Metro Suburban Area*

**Theodore E. Kirousis, Area Director**

The Metro Suburban Area consists of 58 cities and towns and serves more than 3,500 people with mental illness. Metro Suburban's regional service delivery system is built on four local community service networks and three inpatient facilities. Its success is based on a partnership of consumers, providers and citizen advocates working to develop an integrated, accessible service delivery system.

The Area identified issues on which to focus during the fiscal year including: improving the quality of life of consumers; increasing public awareness of treatment and mental illness; expanding housing opportunities; employment support and job development for consumers; expanding case management for DMH consumers; increasing coordination of children's mental health services within the spectrum of children's service agencies; developing new service models to advance rehabilitation and recovery; and improving quality and access to services.

The Area added 13 beds for people with mental illness and substance disorders; obtained 53 housing subsidies; opened a four-bed residence for brain-injured clients statewide who had been residing in state hospitals; and opened a three-bed residential program for mental health clients who are deaf/hearing impaired.

The Area furnished needs assessment data for the comprehensive housing plans of six cities and towns. That served as part of the blueprint for the development of local affordable housing and for the designation of federal and state housing funds to local communities.

The Area supported service providers in efforts to obtain grants and funding.

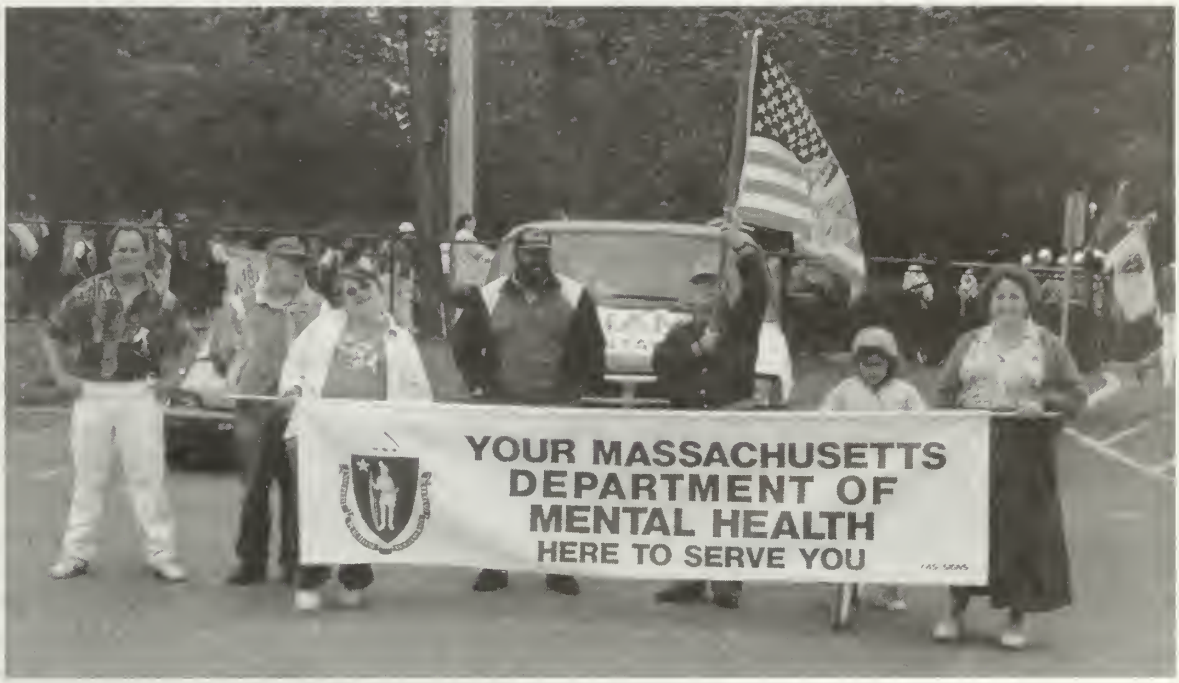
During FY2000, Supported Education and Employment programs provided 192 consumers with employment and 103 clients with education and/or job training. Through Area clubhouses, 173 members participated in transitional employment placement, 181 members were employed through supported-employment jobs and 249 members had independent employment.

Consumers and Alliances United for Supported Education (CAUSE), which employs several consumers among its staff, provided support to 75 students enrolled in higher education, including four in graduate school.

The Area took several steps to improve the health care and well being of consumers, both in the community and facilities.

The Metro Suburban Area SmokeLess Coalition forged a coalition between staff, DPH tobacco control representatives and DMH providers, and used comprehensive surveys to assess smoking behaviors, attitudes and perceptions among the client population. The analysis of this data found that DMH clients begin smoking earlier than the general population; smoke nearly twice as many cigarettes per day as the average smoker; are more highly dependent on nicotine; and are less likely to have plans to stop smoking. Survey data also revealed that nearly 25% began smoking while in a psychiatric setting and only 8% reported that social pressure was a major impetus to stop smoking. In response to this data, the Metro Suburban Area advanced two significant harm reduction initiatives during FY2000: all Metro Suburban Area group residences adopted "smoke-free" environments, and the coalition is developing an educational curriculum to help individuals with serious mental illness to reduce smoking.


***Students attending class at Work, Inc.'s new computer training lab.***




***The Department is proudly represented at Framingham's Flag Day parade.***

The Area continued its End-of-Life research project funded through a grant from the Robert Wood Foundation. The major activities included: establishing an intensive healthcare network by developing an innovative working partnership between mental health and hospice providers, and developing associated research components that included a healthcare preferences questionnaire and a tool to help assess a patient's capacity to understand, appreciate, reason through and choose a health care proxy.

During the fiscal year, all three inpatient facilities were surveyed by either JCAHO or HCFA, which included random, unannounced surveys. The Quincy Mental Health Center received a score of 99, out of a possible 100, on its most recent JCAHO survey.

As a result of efforts by the Medfield Hospital trustees, staff, town officials and local legislators, special state funding was obtained to "mothball" many of the abandoned campus buildings to prevent further deterioration.

The Medfield trustees and the Southwest Suburban Site Board have begun to work on preserving the records of former patients, both through recovery of archival materials at the state hospitals and improving the condition of the patient cemeteries at Medfield.

At Westboro State Hospital, a visiting committee was formed of trustees and human rights committee members to create a presence on each unit and increase awareness and understanding of service provision at the hospital.

Quincy Mental Health Center implemented a weekend mental health education program run by physicians and nursing staff for individuals on the inpatient unit.

While there were several initiatives undertaken by child/adolescent services, the most notable in FY2000 included:

Residential Treatment: The Area funded residential program proposals that included flexible aftercare support services to families upon the return home of youth placed in DMH residential programs.

Court: The Area sought to enhance its relationships with the Juvenile Courts by establishing regular meetings with probation and court clinic personnel in Middlesex and Norfolk counties. Specific projects are underway to support court personnel in accessing appropriate community mental health services. In Middlesex (Framingham) Court, Area staff are collaborating to reduce the number of Child in Need of Service (CHINS) petitions through early identification of family needs and community and court supports.

With strong consumer representation on all Area, site and trustee boards and with consumer aides at all four service sites, the Area remains committed to increasing consumer involvement. On the treatment planning level, a group of consumers piloted a standardized instrument to enhance client participation in the individual service plan process. The five activists were the first consumers to be approved to conduct research by the Central office Research Review Committee. One of these consumer-researchers was a co-presenter at the biannual statewide National Association of Social Work conference, where he advocated for greater participation by consumers in all aspects of treatment and research.

The success of a consumer-run warmline led to an expansion of this model into all four sites. Using the model of a consumer-run enterprise with clinical supervision from current provider organizations, telephone outreach and support service provides peer support and trains clients for positions in service delivery.

# *Southeastern Area*

**Ron Daily, Interim Area Director**

The Southeastern Area is a large, diverse segment of the DMH system. It includes four major cities and nearly 64 towns of varying size. More than 1,130,000 people from different cultural and ethnic groups live in these communities. At any point in time, nearly 8,000 people may be diagnosed with a mental illness and have a substantial decline in their ability to provide for basic self-care. Individuals in this group who have no means to secure needed care constitute the target population for the Department in the Southeastern Massachusetts Area. Nearly 7,000 of these people were served by Area programs in FY2000.

The Southeastern Area is organized into six local sites providing community-based care. Two 16-bed acute care mental health centers and Taunton State Hospital serve residents.

Each of the six community sites-Brockton, Cape Cod and the Islands, Fall River, New Bedford, Plymouth, and Taunton/Attleboro- offers a continuum of mental health services, including emergency care, case management, rehabilitation, support services and psychiatric consultation. These are designed to help DMH clients and others who suffer from mental illness to reside, work and be educated in the least restrictive setting possible. By the close of the fiscal year, the Area had provided a spectrum of non-acute services to 2,691 people with mental illness. Of these, 1,675 were offered case management in addition to at least one other DMH continuing care service.

For more than 25 years, Area and Site management have pursued a tradition of creative intervention and innovation in providing quality mental health care. This continued into FY2000 as the Area achieved continued successes with national accreditation of its Pocasset Mental Health Center and Taunton Hospital, expanded residential capacity, met its revenue targets, and expanded its community rehabilitation services to include state operated programs at Brockton and Fall River.

Some of the other Area accomplishments included:

The Management Information Systems (MIS) department completed three efficiency measures completed in FY2000 . They were: the consolidation of four separate applications into a single, area-wide database, called CARe. This tool reduced redundancy in data entry by 400% and put multiple factor data retrieval power into the hands of all users.

The development and deployment of an automated firearms control database at Corrigan Mental Health Center reduced Corrigan's turnaround time in responding to monthly inquiries from four weeks to 12 hours;

The development and deployment of an inventory control database for consumable items at Taunton State Hospital, that electronically tracks the receipts, distribution, inventory, and cost of these items.

The Southeastern Area Network Performance Improvement workgroup developed a mock performance improvement team to develop a framework to study various methods and tools. The group tracked clients' "missed first appointments" following discharge from inpatient settings to reduce readmissions to hospitals. A pilot project was supported to test the approach and develop an understanding about clients who may be


***Members of the Second Step Players, a theatrical group of consumers of mental health services from Connecticut perform improvisational skits depicting people with mental illnesses in Taunton.***

more likely to miss first appointments and about some of the factors that indicate a need for intervention.

In early 1999, the Area undertook a significant initiative to address the physical health of its clients through formation of a permanent Wellness Committee. This committee meets monthly to share information, review practices and develop resources related to wellness concerns of clients. The committee held its first Area-wide meeting for vendors and DMH providers that fostered the exchange of information on health-related activities across the Area. The meeting resulted in a permanent web page listing the wellness resources and contact information for each site that is now active within the DMH computer system with copies sent to vendors.

The Southeastern Area Staff Development Institute offered 10 major public trainings that included cognitive behavioral therapy, multiculturalism in the new millennium, victims' assistance, wellness, and trainings on other clinical and behavioral issues.

Child/Adolescent case managers in the Southeastern Area and Collaborative Assessment Program (CAP) staff received intensive training on family focused assessment. The premise of this model is that an entire family be involved in an intervention if improvement in the identified client's functioning is to occur. In the series, case managers conducted live assessment interviews with identified clients and their families. The sessions were videotaped, reviewed and critiqued.

Other improvements in Southeastern Area Child/Adolescent operations included:

***Heidi Medeiros, Robert Lima and Shirley Wargot accept awards at the annual disabilities event in Fall River.***

A 30% increase in attendance at support groups for parents of children with serious emotional disturbance;

Development of bi-annual training and consultation protocols for network hospitals and MBHP targeting youth considered for statewide placements, resulting in a 22% reduction in inappropriate referrals to statewide units from network hospitals;

The Plymouth Site helped to develop a partnership between a DMH vendor and local high schools to provide one-on-one mentors;

The Brockton site reduced its reliance on residential placement by 50% from the previous year by reallocating funding to address the needs of maintaining youth in the community; and

The New Bedford and Fall River sites reduced waiting time for completing the eligibility determination process for youth by redeploying staff resources and developing status review mechanisms.

The Southeastern Area improved residential utilization in FY2000. In particular, the Area instituted a process where residential directors received immediate access to data concerning the percentage of residential capacity utilized each month. Residential directors identified trends and ensured that capacity was fully utilized. The Area residential system has averaged 95% or higher enrollment and client absences from programs have been held to less than 5% over the past two years..

A functional assessment tool for residential clients was developed enabling managers to categorize clients into groups based on level of need for supervision. Recently designed prototype reports describing the history of each client's response to residential treatment enable management staff to analyze the client's supervision and rehabilitation needs and relate them to program outcomes, appropriateness of care and contractual expectations.

# *Metro Boston Area*

**Clifford Robinson, Area Director**

The Metro Boston Area, which includes the communities of Boston, Cambridge, Somerville, Brookline, Chelsea, Revere and Winthrop, is a vibrant, richly diverse region, where approximately 7,800 adults and children receive a range of services from 850 DMH employees and hundreds of provider staff. The Area houses four facilities: the Erich Lindemann Mental Health Center, the Solomon Carter Fuller Mental Health Center, the Massachusetts Mental Health Center and the Metro Boston inpatient units of the Lemuel Shattuck Hospital. The Area's 85 adult and child/adolescent case managers link clients to appropriate mental health services.

The Metro Boston Area specializes in innovative and tailored programming. Because it is the most urban of the state's six areas, Metro Boston has developed highly flexible and effective supported housing models that foster the use of different types of subsidies available to DMH clients and provides more choice when it comes to living arrangements in the community.

The Area also has developed specialized residential programs for Latino, Asian and dually diagnosed clients who are served by trained bilingual staff. The Area also has developed specialized residential and community programs for young adults and elderly DMH clients. The new geriatric community rehabilitation support program at the Senior Living on Bellingham Hill project in Chelsea is one of the first of its type in the state.

On any given day in Metro Boston, 1,840 clients are living in DMH funded or supported residential settings.

The following are some of the high lights and achievements in FY2000:

Metro Boston developed a multicultural training collaborative designed to attract minority mental health professionals to training and employment opportunities in the Area. The collaborative's planning partners included representatives from Boston University's School of Medicine, the Simmons College Graduate School of Social Work and Northeastern University's graduate nursing program. The initial planning phase focused on identifying and developing 10 paid internships specifically designed for culturally competent staff. Placements created include doctoral level psychology students in inpatient settings, graduate social work students in clinical and administrative internships, and graduate level nursing positions at one of the Area's community mental health centers.

The Area initiated a collaborative program with the Massachusetts Rehabilitation Commission, the Mayor's Office of the City of Boston and local business community representatives. The consortium identified key partnerships to ensure increased and improved employment opportunities for Area consumers. Targeted to create a team approach to providing initial and ongoing career opportunities to unemployed or underemployed Area clients, the initiative linked Area consumers with prospective employers offering job

*Volunteer Mary McKeon and a Solomon Carter Fuller Mental Health Center consumer at a poetry workshop held twice weekly.*

coaching, pre-employment and on site job training and a variety of work and tax incentives designed to benefit employers and consumers.

In a move to clarify roles and responsibilities during the fiscal year, the Area completed its restructuring of the former Bay Cove Mental Health Center. The site's 125 beds are now known as the Metro Boston inpatient units at Shattuck Hospital. The transition included the development of the Bay Cove Mental Health Center into a local service site similar to the Cambridge/ Somerville and Massachusetts Mental Health Center sites. The Area hopes to move Bay Cove Mental Health Center from the hospital into the community in FY2001.


***Volunteer Joan Werlinsky and a Massachusetts Mental Health Center consumer play Pictionary at Fenwood Inn.***

The Area's nonprofit partner, the Friends of Metro Boston, experienced major program expansion during FY2000. Originally founded to serve consumers of the Erich Lindemann Mental Health Center, the organization grew to serve clients across Metro Boston. Friends events and celebrations provided recreational, social and sports opportunities to more than 4,000 adult consumers throughout the Area.

The fiscal year also saw the establishment of volunteer opportunities at two of the Area's community mental health centers. Two inpatient units totaling 36 beds as well as a 50-bed transitional shelter are now hosting volunteers on a weekly basis.

The Metro Boston Area faces many new challenges in the future. The Area office's upcoming move to the Solomon Carter Fuller Mental Health Center is indicative of the constantly evolving and changing role of its mental health practitioners and administrators. The Area also looks to new leadership at two of its centers.


***Friends of Metro Boston, Inc., basketball league engage in friendly competition at the Police Athletic Gym in South Boston.***

## Alphabetical Listing of Massachusetts Cities, Towns and Area Offices Covered by DMH

*Abington (Southeastern)*
*Acton (Metro Suburban)*
*Acushnet (Southeastern)*
*Adams (Western)*
*Agawam (Western)*
*Alford (Western)*
*Allston (Metro Boston)*
*Amesbury (North East)*
*Amherst (Western)*
*Andover (North East)*
*Arlington (Metro Suburban)*
*Ashburnham (Central)*
*Ashby (Central)*
*Ashfield (Western)*
*Ashland (Metro Suburban)*
*Athol (Western)*
*Attleboro (Southeastern)*
*Auburn (Central)*
*Avon (Southeastern)*
*Ayer (Central)*
*Barnstable (Southeastern)*
*Barre (Central)*
*Becket (Western)*
*Bedford (Metro Suburban)*
*Belchertown (Western)*
*Bellingham (Central)*
*Belmont (Metro Suburban)*
*Berkley (Southeastern)*
*Berlin (Central)*
*Bernardston (Western)*
*Beverly (North East)*
*Billerica (North East)*
*Blackstone (Central)*
*Blandford (Western)*
*Bolton (Central)*
*Boston (Metro Boston)*
*Bourne (Southeastern)*
*Boxboro (Metro Suburban)*
*Boxford (North East)*
*Boylston (Central)*
*Bradford (North East)*
*Braintree (Metro Suburban)*
*Brewster (Southeastern)*
*Bridgewater (Southeastern)*
*Brighton (Metro Boston)*
*Brimfield (Central)*
*Brockton (Southeastern)*
*Brookfield (Central)*
*Brookline (Metro Boston)*
*Buckland (Western)*
*Burlington (Metro Suburban)*
*Byfield (North East)*
*Cambridge (Metro Boston)*
*Canton (Metro Suburban)*
*Carlisle (Metro Suburban)*
*Carver (Southeastern)*
*Charlemont (Western)*
*Charlestown (Metro Boston)*
*Charlton (Central)*
*Chatham (Southeastern)*
*Chelmsford (North East)*
*Chelsea (Metro Boston)*
*Cheshire (Western)*
*Chesterfield (Western)*
*Chicopee (Western)*
*Chilmark (Southeastern)*
*Clarksburg (Western)*
*Clinton (Central)*
*Cohasset (Metro Suburban)*
*Colrain (Western)*
*Concord (Metro Suburban)*
*Conway (Western)*
*Cotuit (Southeastern)*
*Cummington (Western)*
*Dalton (Western)*
*Danvers (North East)*
*Dartmouth (Southeastern)*
*Dedham (Metro Suburban)*
*Deerfield (Western)*
*Dennis (Southeastern)*
*Dighton (Southeastern)*
*Dorchester (Metro Boston)*
*Douglas (Central)*
*Dover (Metro Suburban)*
*Dracut (North East)*
*Dudley (Central)*
*Dunstable (North East)*
*Duxbury (Southeastern)*
*East Boston (Metro Boston)*
*Eastham (Southeastern)*
*East Longmeadow (Western)*
*Easthampton (Western)*
*Easton (Southeastern)*
*Edgartown (Southeastern)*
*Egremont (Western)*
*Erving (Western)*
*Essex (North East)*
*Everett (North East)*
*Fairhaven (Southeastern)*
*Fall River (Southeastern)*
*Falmouth (Southeastern)*
*Fitchburg (Central)*
*Florida (Western)*
*Foxboro (Metro Suburban)*
*Framingham (Metro Suburban)*
*Franklin (Central)*
*Freetown (Southeastern)*
*Gardner (Central)*
*Gay Head (Southeastern)*
*Georgetown (North East)*
*Gill (Western)*
*Gloucester (North East)*
*Goshen (Western)*
*Grafton (Central)*
*Gosnold (Southeastern)*
*Granby (Western)*
*Granville (Western)*
*Great Barrington (Western)*
*Greenfield (Western)*
*Groton (Central)*
*Groveland (North East)*
*Hadley (Western)*
*Hamilton (North East)*
*Hampden (Western)*
*Hanson (Southeastern)*
*Hancock (Western)*
*Hanover (Southeastern)*
*Hardwick (Central)*
*Harwich (Southeastern)*
*Hatfield (Western)*
*Hathorne (North East)*
*Haverhill (North East)*
*Hawley (Western)*
*Heath (Western)*
*Hingham (Metro Suburban)*
*Hinsdale (Western)*
*Holbrook (Southeastern)*
*Holden (Central)*
*Holland (Central)*
*Holliston (Metro Suburban)*
*Holyoke (Western)*
*Hopedale (Central)*
*Hopkinton (Metro Suburban)*
*Hubbardston (Central)*
*Hudson (Metro Suburban)*
*Hull (Metro Suburban)*
*Huntington (Western)*
*Hyannis (Southeastern)*
*Hyde Park (Metro Boston)*
*Ipswich (North East)*
*Jamaica Plain (Metro Boston)*
*Kingston (Southeastern)*
*Lakeville (Southeastern)*
*Lancaster (Central)*
*Lanesboro (Western)*
*Lawrence (North Eastern)*
*Lee (Western)*
*Leicester (Central)*
*Lenox (Western)*
*Leominster (Central)*
*Leverett (Western)*
*Lexington (Metro Suburban)*
*Leyden (Western)*
*Lincoln (Metro Suburban)*
*Littleton (Metro Suburban)*
*Longmeadow (Western)*
*Lowell (North East)*
*Ludlow (Western)*
*Lunenburg (Central)*
*Lynn ( North East)*
*Lynnfield (North East)*
*Malden (North East)*
*Manchester (North East)*
*Mansfield (Southeastern)*
*Marblehead (North East)*
*Marion (Southeastern)*
*Marshfield (Southeastern)*
*Mashpee (Southeastern)*
*Mattapan (Metro Boston)*
*Mattapoisett (Southeastern)*
*Maynard (Metro Suburban)*
*Medfield (Metro Suburban)*
*Medford (North East)*
*Medway (Central)*
*Melrose (Northeast)*
*Mendon (Central)*
*Merrimac (North East)*
*Methuen (North East)*
*Middleboro (Southeastern)*
*Middlefield (Western)*
*Middleton (North East)*
*Milford (Central)*
*Millbury (Central)*
*Millis (Metro Suburban)*
*Milton (Metro Suburban)*
*Millville (Central)*
*Monroe (Western)*
*Monson (Western)*
*Montague (Western)*
*Monterey (Western)*
*Montgomery (Western)*
*Mount Washington (Western)*
*Nahant (North East)*
*Nantucket (Southeastern)*
*Natick (Metro Suburban)*
*Needham (Metro Suburban)*
*New Ashford (Western)*
*New Bedford (Southeastern)*
*New Braintree (Central)*
*Newbury (North East)*
*Newburyport (North East)*
*New Marlboro (Western)*
*New Salem (Western)*
*Newton (Metro Suburban)*
*North Adams (Western)*
*North Andover (North East)*
*North Attleboro (Southeastern)*
*Norfolk (Metro Suburban)*
*Northampton (Western)*
*Northboro (Metro Suburban)*

*Northfield (Western)*
*Norton (Southeastern)*
*Norwell (Metro Suburban)*
*Norwood (Metro Suburban)*
*Oakham (Central)*
*Oak Bluffs (Southeastern)*
*Onset (Southeastern)*
*Orange (Western)*
*Orleans (Southeastern)*
*Osterville (Southeastern)*
*Otis (Western)*
*Oxford (Central)*
*Palmer (Western)*
*Paxton (Central)*
*Peabody (North East)*
*Pelham (Western)*
*Pembroke (Southeastern)*
*Pepperell (Central)*
*Peru (Western)*
*Petersham (Western)*
*Pittsfield (Western)*
*Phillipston (Western)*
*Plainfield (Western)*
*Plainville (Metro Suburban)*
*Plymouth (Southeastern)*
*Plympton (Southeastern)*
*Pocasset (Southeastern)*
*Princeton (Central)*
*Provinctown (Southeastern)*
*Quincy (Metro Suburban)*
*Randolph (Metro Suburban)*
*Raynham (Southeastern)*
*Reading (North East)*
*Rehoboth (Southeastern)*
*Revere (Metro Boston)*
*Richmond (Western)*
*Rochester (Southeastern)*
*Rockland (Southeastern))*
*Rockport (North East)*
*Roslindale (Metro Boston)*
*Rowe (Western)*
*Rowley (North East)*
*Roxbury (Metro Boston)*
*Royalston (Western)*
*Russell (Western)*
*Rutland (Central)*
*Salem (North East)*
*Salisbury (North East)*
*Sandisfield (Western)*
*Sandwich (Southeastern)*
*Saugus (North East)*
*Savoy (Western)*
*Scituate (Metro Suburban)*
*Seekonk (Southeastern)*
*Sharon (Metro Suburban)*
*Sheffield (Western)*
*Shelburne (Western)*
*Sherborn (Metro Suburban)*
*Shirley (Central)*
*Shrewsbury (Central)*
*Shutesbury (Western)*
*Somerset (Southeastern)*
*Somerville (Metro Boston)*
*Southampton (Western)*
*Southboro (Metro Suburban)*
*Southbridge (Central)*
*Southwick (Western)*
*Spencer (Central)*
*Springfield (Western)*
*Sterling (Central)*
*Stockbridge (Western)*
*Stoneham (North East)*
*Stoughton (Southeastern)*
*Stow (Metro Suburban)*
*Sturbridge (Central)*
*Sudbury (Metro Suburban)*
*Sunderland (Western)*
*Sutton (Central)*
*Swampscott (North East)*
*Swansea (Southeastern)*
*Taunton (Southeastern)*
*Templeton (Central)*
*Tewksbury (North East)*
*Tisbury (Southeastern)*
*Tolland (Western)*
*Topsfield (North East)*
*Townsend (Central)*
*Truro (Southeastern)*
*Turners Falls (Western)*
*Tyngsboro (North East)*
*Tyringham (Western)*
*Upton (Central)*
*Uxbridge (Central)*
*Wakefield (North East)*
*Wales (Central)*
*Walpole (Metro Suburban)*
*Waltham (Metro Suburban)*
*Ware (Western)*
*Wareham (Southeastern)*
*Warren (Central)*
*Warwick (Western)*
*Washington(Western)*
*Watertown (Metro Suburban)*
*Wayland (Metro Suburban)*
*Webster (Central)*
*Wellesley (Metro Suburban)*
*Wellfleet (Southeastern)*
*Wendell (Western)*
*Wenham (North East)*
*Westboro (Metro Suburban)*
*Westfield (Western)*
*Westford (North East)*
*Westminster (Central)*
*Westport (Southeastern)*
*Weston (Metro Suburban)*
*Westwood (Metro Suburban)*
*Weymouth (Metro Suburban)*
*Whately (Western)*
*Whitinsville (Central)*
*Whitman (Southeastern)*
*Wilbraham (Western)*
*Williamsburg (Western)*
*Williamstown (Western)*
*Wilmington (Metro Suburban)*
*Winchendon (Central)*
*Winchester (Metro Suburban)*
*Windsor (Western)*
*Winthrop (Metro Boston)*
*Woburn (Metro Suburban)*
*Woods Hole (Southeastern)*
*Worcester (Central)*
*Worthington (Western)*
*Wrentham (Metro Suburban)*
*Yarmouth (Southeastern)*

Commonwealth of Massachusetts
Department of Mental Health
25 Staniford Street
Boston, MA 02114
(617) 626-8000